AHMED SHARAF, DDS

— General Dentist Providing Oral Surgery Services —

954.651.1254 (cell) sharaf@sharafdds.com www.sharafdds.com

DENTAL IMPLANT FORM

Patient______________________________ **DOB**____/____/______ **Appointment Date**____/____/______

Restorative Dentist____________________________________ **Phone #**__________________

Restorative Dentist's Signature________________________ **Email**______________________

IMPLANT SYSTEM:

☐ **Neodent**: ☐ Bone Level ☐______________________

☐ **Straumann**: ☐ Bone Level ☐______________________

☐ Other____

For additional assistance, contact:

Casey Ingram @ 512.420.7257
casey.ingram@neodent.com
Cecily Kertson @ 512.632.8032
cecilykertson@straumann.com

Tooth #______ *(attach sticker)*

Size: ______ mm x ______ mm

☐ Cover Screw
☐ Healing Abutment D_____ H_____
☐ Uncovering Date _____/_____/_____

Tooth #______ *(attach sticker)*

Size: ______ mm x ______ mm

☐ Cover Screw
☐ Healing Abutment D_____ H_____
☐ Uncovering Date _____/_____/_____

Tooth #______ *(attach sticker)*

Size: ______ mm x ______ mm

☐ Cover Screw
☐ Healing Abutment D_____ H_____
☐ Uncovering Date _____/_____/_____

Bone Graft

Sinus Lift: ☐ Yes ☐ No

Date _____/_____/_____

Area____

Materials______________________________________

☐ Index taken on tooth: #______, #______, #______, #______ Date____/____/______

☐ Ready for restoration implant: #______, #______, #______, #______ Date____/____/______

☐ Coping & Analog: ______Mailed to your office ______Sent with patient Date____/____/______

If mailed, please allow adequate shipping time before making impression appointment.

NOTES____

We recommend the use of only Neodent- or Straumann-labeled abutments; please call if you have any questions.

Dr. Sharaf's Signature____________________________________ Date______/_____/__________